DRAFT
Table of Contents

DRAFT

DRAFT

1.0 Description of the Service

The Maternity Care Coordination Program (MCCP) provides Medicaid targeted case management services to eligible women during and after pregnancy and provides intervention as early in pregnancy as possible to promote a healthy pregnancy and positive birth outcome. Section 1915(g)(2) of the Social Security Act defines case management services as services that will assist individuals eligible under the Medicaid plan in gaining access to needed medical, social, educational, and other services. Targeted case management services are case management services that are furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specified areas. The required components of case management are assessment, care planning, referral and linkage, and monitoring/follow-up. Participation in MCCP is voluntary.

MCCP utilizes both Maternity Care Coordinators (MCCs) **and** Maternal Care Workers (MCWs) to perform program functions. Services are no longer rendered in separate programs. Their duties are as follows:

1.1 Maternity Care Coordinator

The MCC can perform all required programmatic activities including assessment, care planning, referral and linkage, and monitoring/follow-up services (see **Section 5.0** for more information). The MCC supervises the activities of the MCW(s).

1.2 Maternal Care Worker

The MCW performs referral and linkage as well as monitoring/follow-up activities under the supervision of an MCC.

Note: Maternal Care Workers were formerly known as Maternal Outreach Workers.

For those agencies that do not employ MCWs, MCCs must perform all program-related activities.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Limitations

Pregnant and postpartum women who receive Medicaid are eligible for this service. Women who experience a spontaneous abortion (miscarriage), a therapeutic abortion, fetal demise, or a molar pregnancy are also eligible to receive this service.

Note: The postpartum period is at least 60 days following termination of the pregnancy for any reason. The postpartum period ends on the last day of the month in which the 60th day falls. (42 CFR 447.53).

DRAFT

2.3 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid Billing Guide*:** http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are medically necessary health care services to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows

how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Medicaid covers MCCP services when they are medically necessary and

a. the service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

b. the service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Medical Necessity Criteria

MCCP services are covered for women who are pregnant or experience a spontaneous abortion (miscarriage), a therapeutic abortion, fetal demise, or molar pregnancy through the end of the postpartum period.

Note: The postpartum period is at least 60 days following termination of the pregnancy for any reason. The postpartum period ends on the last day of the month in which the 60th postpartum day falls. (42 CFR 447.53).

3.3 Criteria for Additional Coverage

Maternity Care Coordination services are covered for up to six or eight units per month, depending on the diagnosis of the participant (one unit = 15 minutes). **For more information, see Section 5.0.** Additional units may be requested through the claims adjustment process, which is detailed in the Basic Medicaid Billing Guide at http://www.ncdhhs.gov/dma/medbillcaguide.htm. Coverage of additional units will be considered only when conditions of coverage are met and documentation supports the following medical necessity factors (or high-risk criteria):

a. Medical high-risk factors related to pregnancy outcome such as preterm labor, history of prior preterm labor, hypertension, pre-eclampsia, diabetes, suspected fetal growth retardation, multiple pregnancy, renal disease, HIV infection/AIDS, and/or other high-risk medical conditions

b. Substance abuse (alcohol or drugs) or history of substance abuse with potential negative impact on current pregnancy

c. Tobacco use or history of tobacco use with potential negative impact on current pregnancy

d. Child abuse, family violence, or a stressful life situation which could have a negative impact on the current pregnancy

e. Behavioral high-risk factors that can have a negative impact on the pregnancy such as suicidal ideation/behavior, self injurious behavior, schizophrenia, bipolar

disorder, major depressive disorder, mood disorder, anxiety disorder, eating disorders, postpartum depression, and/or other high-risk mental health conditions

f. Mental impairment/retardation

g. Teenage pregnancy

4.0 When the Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

MCCP services are not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**

b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**

c. the service unnecessarily duplicates another provider's procedure; or

d. the service is experimental, investigational, or part of a clinical trial.

4.2 Non-Covered Services

Medicaid coverage of targeted case management services **does not** include the provision of direct services (medical, educational, or social).

Time spent preparing and completing documentation, when conducted separately from case management services, is not billable.

4.3 Third Party Liability

In accordance with section 1902(a)(25) of the Social Security Act, Medicaid coverage of case management services or targeted case management services is available only if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

5.0 Requirements for and Limitations on Coverage

5.1 Service Limitations

5.1.1 Maternity Care Coordinator

Services provided by the MCC for the following ICD-9-CM diagnosis codes are limited to six units (90 minutes) per month:

DRAFT

Code	Description
V22.0	Normal pregnancy; Supervision of normal first pregnancy
V22.1	Normal pregnancy; Supervision of other normal pregnancy
V23.0	Supervision of high-risk pregnancy; Pregnancy with history of infertility
V23.1	Supervision of high-risk pregnancy; Pregnancy with history of trophoblastic disease
V23.2	Supervision of high-risk pregnancy; Pregnancy with history of abortion
V23.7	Pregnancy with other poor obstetric history; Insufficient prenatal care
V23.9	Unspecified high-risk pregnancy
V24.0	Postpartum care and examination; Immediately after delivery
V24.2	Postpartum care and examination; Routine postpartum follow-up

Services provided by the MCC for the following ICD-9-CM diagnosis codes are limited to eight units (120 minutes) per month:

Code	Description
V23.3	Supervision of high-risk pregnancy; Grand multiparity
V23.41	Pregnancy with other poor obstetric history; Pregnancy with history of pre-term labor
V23.49	Pregnancy with other poor obstetric history; Pregnancy with other poor obstetric history
V23.5	Pregnancy with other poor obstetric history; Pregnancy with other poor reproductive history
V23.81	Other high-risk pregnancy; Elderly primigravida
V23.82	Other high-risk pregnancy; Elderly multigravida
V23.83	Other high-risk pregnancy; Young primigravida
V23.84	Other high-risk pregnancy; Young multigravida
V23.89	Other high-risk pregnancy; Other high-risk pregnancy

5.1.2 Maternity Care Worker

Services provided by the MCW are limited to seven units (105 minutes) per month.

5.1.3 Additional Units

Coverage of services that exceed the limitations listed in **Sections 5.1.1** and **5.1.2** will only be considered when conditions of coverage are met and documentation supports the medical necessity criteria (or high-risk criteria) indicated in **Section 3.3**. Additional units for services rendered by the MCC may be requested through the claims adjustment process.

5.2 One-on-One, Face-to-Face Visits

One-on-one, face-to-face visits must be conducted with the participant at least three times during the pregnancy, preferably once per trimester, starting with the initial assessment and the development of the care plan. For participants with high-risk medical conditions or diagnoses, there must be a monthly one-on-one contact between MCCP staff and the participant (face-to-face visits are strongly encouraged). When a participant is in need of

postpartum services due to an abortion, fetal demise or a molar pregnancy, a one-on-one, face-to-face visit must be conducted at least once after the procedure occurs or condition is diagnosed.

For more information on high-risk criteria, refer to **Section 3.3.**

5.3 Participant Responsibilities

MCCP services require involvement from the participant to assist in the successful implementation of the program. The participant's responsibilities include

a. selecting a primary care provider and/or prenatal care provider and informing the MCCP staff of the name of the provider;

b. agreeing to work with the MCC to develop a care plan based on the participant's identified needs and concerns, with provider and program needs and concerns documented separately; and

c. agreeing to follow the care plan as developed with input from the participant, family, MCCP staff, and the prenatal care provider.

5.4 Case Management Components

MCCP staff must perform the four required components of case management as they are listed below.

5.4.1 Assessment

Assess each participant to determine service needs, including activities that focus on needs identification, and to determine the need for any medical, educational, social or other services. **The assessment must be performed by a MCC.**

5.4.1.1 Screening

The MCC must complete the MCCP Intake Screening form (DHHS T1513) for each individual identified for MCCP services. The MCCP Intake Screening form must be completed during a one-on-one, face-to-face contact. The MCCP Intake Screening form requires the MCC to verify pregnancy or the 60-day postpartum period.

The following items are acceptable forms of verification:

a. Positive pregnancy test, ultrasound report, prenatal medical record or record of positive fetal heart tones

b. Copy of participant's current month's Medicaid identification card **(this form of verification is acceptable only if the participant has MPW coverage)**

c. Child's birth/death certificate

d. Statement from a health care provider that specifies when the spontaneous abortion (miscarriage), therapeutic abortion, fetal demise or molar pregnancy occurred

It is preferable that a copy of the pregnancy or 60-day postpartum period verification be kept in the participant's chart. However, if the MCC is unable to obtain copies, but has seen the necessary verification, documentation that they have seen the requested documents and the reason why they could not be copied is sufficient.

DRAFT

This information must be documented on the MCCP Intake Screening form (DHHS T1513).

If the MCC is unable to verify pregnancy or the 60-day postpartum period, the participant will not be eligible for MCCP services. The MCC does not need to complete the remainder of the MCCP Intake Screening form; however, the MCC must

a. obtain the participant's signature on the MCCP Intake Screening form (DHHS T1513);
b. explain the appeal rights to the participant;
c. provide the participant with a copy of the Baby Love Program brochure, which can be found at http://www.ncdhhs.gov/dma/babylove.html;
d. explain to the participant that if any changes occur in her situation, she has the right to re-apply for MCCP services at any time during her pregnancy or postpartum period; and
e. provide the participant with a denial letter within two business days that documents the participant's appeal rights [10A NCAC 22H.0101(c)].

If the MCC verifies pregnancy or the 60-day postpartum period, the MCC must then complete the remainder of the MCCP Intake Screening form (DHHS T1513).

If after the initial screening is completed it is determined that the participant is eligible for MCCP services, but chooses not to enroll in the program, the MCC must

a. obtain the participant's signature on the MCCP Intake Screening form (DHHS T1513);
b. provide the participant with a copy of the Baby Love Program brochure, which can be found at http://www.ncdhhs.gov/dma/babylove.html; and
c. explain to the participant that if any changes occur in her situation, she has the right to re-apply for MCCP services at any time during her pregnancy or postpartum period.

If it is determined that the participant is eligible for MCCP services and wishes to enroll in the program, then the MCC may begin the enrollment process.

Note: If the recipient does not enroll in the program, the MCCP screening is still covered.

5.4.1.2 Enrollment

Enrollment in MCCP must occur at a one-on-one, face-to-face visit. Enrollment must also include an explanation of the services. Based upon availability, the participant has the "freedom of choice" to enroll in MCCP services with any N.C. Medicaid-approved MCCP provider. Participants receiving prenatal care in the private sector are also eligible to participate in MCCP. Enrollment can take place in

any location that is convenient for the participant and the MCCP provider agency.

The enrollment process is completed when the following activities have been achieved:

a. An MCCP Intake Screening form (DHHS T1513) has been completed.
b. The participant has been provided with an explanation of the program.
c. A signed MCCP Letter of Agreement (DMA-3004) has been obtained.

5.4.1.3 Initial Assessment

The MCC is required to complete an MCCP Strengths/Needs Assessment form (DMA 2007) for all pregnant and postpartum women identified for MCCP services. The purposes of the initial assessment are to

a. obtain the participant's history (medical, social, etc.);
b. identify the participant's strengths and needs, and complete related documentation;
c. gather information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the participant's needs; and
d. establish rapport with the participant, prenatal care provider, medical care providers, and other support persons.

The initial assessment must be performed during a one-on-one, face-to-face visit. The MCC must complete the initial assessment within 30 days of the participant's enrollment in MCCP. Each section of the Strengths/Needs Assessment form must be completed, unless the participant objects to a particular section. In this situation, the MCC must document the participant's objection(s) on the assessment form.

5.4.2 Care Planning

The MCC is responsible for developing an individualized, comprehensive MCCP Care Plan (DMA 2009) based on the information collected through the assessment that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible participant. The care plan includes activities such as ensuring the active participation of the eligible participant in achieving her objectives and working with the participant and others to develop goals and identify a course of action to respond to the needs assessed. **The care plan must be developed by an MCC.**

The purpose of the care plan is to document the work being done by both the MCC and participant, including the participant's family if they are available. Every need documented on the MCCP Assessment form (DMA 2007) must be addressed on the Care Plan (DMA 2009). The MCC must collaborate with the medical care provider to ensure any issues or concerns identified by the medical

care provider are included in the care plan. The care plan must be updated whenever changes occur and must justify the interventions that are taking place.

Key points in the development of the care plan include

a. Agreement between the participant and the MCC on areas to be addressed, including priorities identified by the participant and the MCC
b. Goals and activities written in clear, behavioral terms indicating specific responsibilities of the participant, family, MCC, MCW, and other providers, and time lines for accomplishment/reassessment
c. The participant's and her family's ability to meet their own needs and use available support system
d. Modification according to changes in identified needs

The MCC and the participant must sign the initial care plan within 30 days of the participant's enrollment in MCCP. Any changes or modification made to the existing care plan(s) must be initialed by the MCC.

Note: MCCP staff can consist of a MCC or a MCW. However, MCWs can only perform duties associated with referral and linkage and case monitoring/follow-up services.

When an MCCP agency employs MCW staff, the MCC must provide specific guidance on MCW duties. The MCC must document the MCW's duties in the participant's care plan which must be updated at least monthly. **MCW duties must be distinctly different from MCC duties to avoid duplication of services.** Collaboration between the MCC and the MCW must include documentation in the MCCP narrative notes of an exchange of information or evidence of communication between the MCC and the MCW.

Note: All activities associated with the provision of MCCP services must be properly documented in the care plan or narrative notes in order for services to be covered.

5.4.3 Referral and Linkage

This component includes activities designed to help a participant obtain needed services, including activities that help link Medicaid-eligible individuals with medical, social, and educational providers and/or other programs and services that are capable of providing needed services. For example, making referrals to providers for needed services and scheduling appointments is considered case management. **This component can be performed by an MCW or an MCC.**

MCCP staff must document on the participant's care plan all referrals and linkages. A copy of the care plan must be forwarded to the participant's prenatal care provider. Covered referral and linkage services, also known as maternal support services include

a. Childbirth Education Classes
b. Maternal Care Skilled Nurse Home Visit
c. Health and Behavior Intervention
d. Dietary Evaluation and Counseling (medical nutrition therapy)
e. Home Visit for Postnatal Assessment and Follow-up Care

DRAFT

Note: Enrollment in MCCP is not necessary in order to benefit from these services. When providing referral and linkage services, MCCP service providers are strongly encouraged to utilize and inform the participant about all available resources.

Note: Referral and linkage services can be rendered during one-on-one, face-to-face visits or conducted by telephone. These services must be 15 minutes or longer in duration in order to be covered and the MCCP staff must make contact with the participant, relevant care provider(s) or a family member involved in the participant's care. Leaving or receiving a message is not considered a Medicaid covered service.

5.4.4 Monitoring/Follow-up

This component includes activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the participant. The activities and contacts may be with the participant, family members, providers or other entities. Monitoring can be conducted as frequently as necessary to help determine

a. whether services are being furnished in accordance with the participant's care plan;
b. the adequacy of the services in the care plan; and
c. changes in the needs or status of the participant.

This function includes providing information to the participant to assist in making informed decisions about service delivery and making necessary adjustments in the care plan and service arrangements with providers.

Case monitoring/follow-up activities are based on the participant's written care plan. It is the MCCP staff's responsibility to monitor and coordinate all the MCCP activities, referrals, and follow-up services.

5.4.4.1 MCCP Staff Monitoring/Follow-up Responsibilities

The MCC must

a. review the assessment for new concerns or changes in the status of previously identified concerns; and
b. update and revise the care plan as needed, including participant/program priorities, and participant/family relationships.

The MCW (when available) must

a. make necessary referrals and follow-up on previous referrals and
b. discuss future plans and/or transitions to other programs or services.

Note: Though many monitoring/follow-up activities can be performed by an MCW, the MCC must reassess the needs/concerns of the participant, as necessary, and make changes to the care plan. In the absence of an MCW, the MCC must complete all four of the aforementioned responsibilities.

DRAFT

5.4.4.2 Monitoring/Follow-up Visits

Although frequency and duration of services are to be determined by the needs of the participant, the participant must be contacted at least once per month by the MCC. MCCP case monitoring/follow-up visits can be conducted during a one-on-one, face-to-face visit or by telephone. When care coordination is conducted by telephone, it must be 15 minutes or longer in duration in order to be covered and the MCCP staff must make contact with the participant, relevant care provider(s) or a family member involved in the participant's care. If MCCP staff or the participant, their family members or relevant care providers leave a telephone message, the time spent leaving or listening to the message is not covered. Ongoing care coordination visits cannot be billed for services provided to participants in a group setting. When the participant is contacted, MCCP staff must document the status of the identified needs/concerns and if necessary, update the care plan.

Note: A prenatal clinical visit does not constitute an MCCP visit and cannot be covered as a monitoring/follow-up visit.

As a part of their monitoring/follow up activities, MCCP staff must ensure that the participant is properly informed about topics that affect them and their new baby, if applicable. These topics include, but are not limited to, the following:

a. The importance of early and continuous prenatal care
b. The importance of adherence to prenatal care provider's care plan
c. The use of any drugs/medications during pregnancy unless prescribed by a prenatal provider
d. Signs and symptoms of preterm labor
e. Tobacco usage, second-hand smoke, and smoking cessation programs
f. Substance/alcohol usage during pregnancy and assistance with locating support groups/treatment
g. Environmental and occupational hazards related to pregnancy
h. Positive behaviors, during pregnancy and after
i. Childbirth education classes available in the agency and the state
j. Preparation for the baby
k. Breastfeeding
l. Infant safety seats, infant safety law, and seat usage
m. Family planning and the family planning waiver
n. Weight loss after pregnancy
o. The psychological and emotional effects of abortion
p. The importance of postabortal care

DRAFT

Note: The topics and the date that they were discussed with the participant must be documented on the participant's care plan or the MCCP narrative notes.

5.5 Case Conferencing

Case conferencing is required when the participant has more than one case manager providing services. When Medicaid-eligible participants receive other case management services, MCCP staff **must** coordinate services with the other case manager(s) and send the documented care plan to the participant's prenatal provider. Case conferencing is also required when the participant meets high-risk criteria, as defined in **Section 3.3**. The purposes of case conferencing are as follows:

a. to coordinate participant services;
b. to clarify participant issues;
c. to identify issues/concerns of the medical care provider;
d. to review interventions to date;
e. to revise care plan as necessary;
f. to increase team communication; and
g. to eliminate duplication of services.

Once it is determined that the participant has more than one case manager or meets the high-risk criteria as defined in **Section 3.3**, a case conference must occur within 30 days of the initial assessment. A case conference should be held two times during the pregnancy to ensure that services are not duplicated and the care plan is adhered to. Apart from the formal case conference, the MCCP staff **must** correspond with other case managers and relevant caregivers as needed. MCCP staff must forward copies of the care plan and any revised care plans to the participant's prenatal care provider. Participants in the case conference may include but are not limited to

a. Maternal Care Coordinators
b. Maternal Care Workers
c. Prenatal care providers
d. Child Service Coordinators
e. Supervisor(s)
f. Maternal Health Nurses
g. Medical care providers
h. Other case managers
i. Other health care professionals

Each case conference must be documented on the MCCP Case Conference Summary form (DMA 2011). The form must be dated and signed by MCCP staff. Documentation of case conferences, including a list of those who participated, must be maintained in the participant's case record.

Note: Case conferencing is covered for up to 30 minutes per session.

5.6 Place of Service

An MCCP visit may be provided either in a clinic/office, home, or a mutually agreeable site for the MCCP staff and the participant. The place of service must be documented in

the case record. The MCC is required to make a minimum of one home visit to the participant's home. If the participant refuses to allow a home visit, then the MCCP staff must document the refusal in the participant's case record.

5.7 Missed Appointments

Missed appointments and attempts to contact or reschedule are not covered through MCCP. MCCP staff must follow up on all missed prenatal and other MCCP appointments **within 2 weeks** or ensure that follow-up is conducted by another staff member. At a minimum, **three** attempts must be made to follow-up on missed appointments. The missed appointments and attempts to follow up must be documented in the participant's case record. If written correspondence is sent as a means of follow-up, a copy of the letter must be placed in the participant's case record.

5.8 Transportation

The purpose of transportation is to assure that participants keep their health care appointments. The MCCP staff is responsible for coordinating transportation services. The local department of social services (DSS) is available to assist Medicaid-eligible participants with transportation to their health care appointments.

Note: Transporting a participant to and from providers and programs for needed services is not a covered service under MCCP. Transportation is not a case management activity.

5.9 Postpartum Period

If a participant is receiving MCCP services during the postpartum period, the MCCP staff must provide the following services prior to case closure:

a. Services for the MCCP participant:
   1. Notify the participant that MCCP services will terminate at the end of the postpartum period.
   2. Assist in locating a medical provider for her ongoing health needs.
   3. Refer and assist in obtaining appropriate family planning services, including, but not limited to, enrollment in the Family Planning Waiver Program.
   4. Provide and assist with information on well-child care.
   5. Provide and assist with information on postabortal care
   6. Refer and arrange for postpartum Women, Infants, and Children Special Supplemental Nutrition program (WIC) certification.
   7. Provide information on community resources and assist with referrals to these resources and other agencies.
   8. Provide interconception health information and links to available resources.

b. Services for the infant:
   1. Ensure that the local DSS has been notified of the infant's birth and that the mother of the newborn has received Medicaid enrollment information for the child.
   2. Assist in locating a medical provider for ongoing well-child and sick care.
   3. Ensure that the mother has a Health Check program brochure and understands that preventive services are available for Medicaid-eligible children under the age of 21.

4. Consult with the local Health Check program coordinator regarding medical appointments for the infant and arranging medical transportation.
5. Refer and arrange for WIC certification for the infant.
6. Coordinate the transition of care coordination services to the Child Service Coordination or Infant-Toddler programs, if necessary.

Note: The postpartum period is at least 60 days following termination of the pregnancy for any reason. The postpartum period ends on the last day of the month in which the 60th day falls (42 CFR 447.53).

5.10 Closure

MCCP services must be closed when one of the following conditions occurs:

a. The services are terminated at the end of the postpartum period.
b. The participant is lost to follow-up after up to three consecutive months of attempts to locate.
c. The participant moves out of state.
d. The participant expires during the eligibility period.
e. The participant states she no longer wishes to receive services.
f. The identified needs/concerns have been resolved and follow-up services are no longer needed.
g. The participant transfers out of the county or changes provider agencies.

   Note: If the participant transfers out of the county or changes provider agencies, then the MCCP staff must follow the guidelines listed in **Section 5.11**.
h. The participant is incarcerated during the eligibility period.
i. The participant is no longer eligible for Medicaid.

   Note: Once a participant is deemed ineligible for Medicaid, any services rendered are not covered by Medicaid. Thus, if the provider chooses to serve someone who is ineligible for Medicaid, MCCP services rendered will not be covered by Medicaid.

If the identified needs/concerns have been resolved and follow-up services are no longer needed, or services are terminated at the end of the postpartum period or the participant is no longer Medicaid eligible, MCCP staff must complete the following activities:

a. Provide and assist with information on community resources.
b. Update the participant's care plan to reflect the final MCCP service status.
c. Notify the participant and caregivers that MCCP services have terminated and the reason for termination.
d. Document in the care plan or narrative notes the date of closure, reason for termination, and date of notification of participant.
e. Complete and submit a Pregnancy Outcome Summary form (DHHS T1514).
f. Notify the participant's prenatal provider that MCCP services have terminated and the reason for termination.

If the participant states she no longer wishes to receive services, MCCP staff must complete the following activities:

a. Document the request in participant's case record.
b. Update the participant's care plan to reflect the final MCCP service status.
c. Document in the care plan or narrative notes the date of closure, reason for termination, and date of notification of participant.
d. Provide the participant with a Baby Love Program brochure.
e. Explain to participant that she may re-apply at any time.
f. Complete and submit a Pregnancy Outcome Summary form (DHHS T1514).
g. Notify the participant's prenatal provider that MCCP services have terminated and the reason for termination.

If the participant is lost to follow-up after three consecutive months of attempts to locate the participant, MCCP staff must complete the following activities:

a. Document attempts to locate in participant's case record.
b. Document in the care plan or narrative notes the date of closure and reason for termination.
c. Complete and submit a Pregnancy Outcome Summary form (DHHS T1514).
d. Notify the participant's prenatal provider that MCCP services have terminated and the reason for termination.

If the participant expires during the eligibility period, then the MCCP must complete the following activities:

a. Document in the care plan or narrative notes the date of closure and reason for termination.
b. Complete and submit a Pregnancy Outcome Summary form (DHHS T1514).
c. Notify the participant's prenatal provider.

If the participant is incarcerated during the eligibility period, MCCP staff must complete the following activities:

a. Update the participant's care plan to reflect the final MCCP service status.
b. Document in the care plan or narrative notes the date of closure and reason for termination.
c. Complete and submit a Pregnancy Outcome Summary form (DHHS T1514).
d. Notify the participant's prenatal provider that MCCP services have terminated and the reason for termination.

If the participant returns and desires to resume program participation, MCCP staff must re-evaluate the participant for MCCP services beginning with an update of the MCCP Strengths /Needs Assessment form (DMA 2007).

5.11 Transfers

If the participant transfers to another county, transfers to another MCCP provider agency within her county, or transfers to another MCCP provider outside her county, then the transferring MCCP provider agency must complete the following activities:

a. Obtain a signed medical release of information.
b. Update the participant's care plan.
c. Notify appropriate caregivers of the participant's status change.

d. Initiate contact with the new MCCP agency by letter/telephone to review the participant's case file and share significant information.

e. Discuss transfer of services with the participant and assist with information regarding the new provider.

f. Complete and submit a Pregnancy Outcome Summary form (DHHS T1514).

g. Transfer a copy of the care coordination record(s) including all required forms to the new MCCP provider agency.

h. Notify the participant's prenatal provider of the transfer.

The MCC in the receiving agency must also coordinate activities to ensure a smooth transition for the participant. These activities include the following:

a. Contacting the participant within 30 days of notification of transfer

b. Scheduling an appointment to reassess needs and update the care plan

c. Reviewing care coordination record(s)

Note: If the participant moves to another county before they inform their MCC, then the new MCCP provider agency can obtain the signed medical release of information and send it to the previous MCC in order to obtain copies of the MCCP case record for the participant.

5.12 Prior Approval

Prior approval is not required in order to obtain MCCP services.

6.0 Providers Eligible to Bill for the Service

Local health departments, community and migrant health centers, federally qualified health centers, rural health clinics, regional perinatal providers, and private practitioners who meet Medicaid's qualifications for participation and are enrolled with the N.C. Medicaid program to provide MCCP case management services are eligible to bill for the service.

Agencies must be certified jointly by the Division of Medical Assistance (DMA) and the Division of Public Health (DPH) in order to be considered for enrollment as a MCCP case management agency.

6.1 Certification Requirements

To qualify for coverage of MCCP services, a provider shall meet all the criteria specified below.

a. Ensure the provision of MCCP services by qualified case managers.

b. Ensure supervision of MCCP staff by qualified supervisors.

c. Enroll each physical site with DMA as a provider of MCCP case management services.

d. Meet applicable state and federal laws governing the participation of providers in the Medicaid program.

e. Maintain DMA/DPH certification as a qualified provider of MCCP case management services.

f. Demonstrate compliance with initial and ongoing certification processes.

g. Demonstrate compliance with the monitoring and evaluation of case management records through a quality assurance plan.

h. Make recipient records available for DMA and/or DPH to review.

i. Notify DMA/DPH of proposed changes such as business owner or name change, case manager or supervisor change, address or telephone number change, email address change, or plans for business dissolution within 30 days of proposed change.

6.2 Certification and Decertification Process

DMA and DPH are jointly responsible for certifying qualified MCCP case management providers to render services in accordance with professionally recognized standards and as specified by this policy, and also for decertifying those MCCP case management agencies that fail to render services in accordance with professionally recognized standards and as specified by this policy.

6.2.1 Initial Certification

A provider shall comply with all the requirements specified below. The initial certification is valid for four years.

a. Submit a complete and signed application to DMA that includes
   1. Description of the core components described in **Section 5.0**
   2. Quality assurance plan, including the monitoring and evaluation of case management records (see **Section 7.4**)
   3. Counties to be served
   4. Hours of operation
   5. Confidentiality policy
   6. Recipient grievance policy
   7. Non-discrimination policy
   8. Code of ethics policy
   9. Conflict of interest policy
   10. Electronic records policy, if applicable
   11. MCCP services financial plan
   12. Record retention policy
   13. Recipient rights policy
   14. Transfer and discharge policy
   15. Identification of abuse, neglect, and exploitation policy
   16. Human resource policy, to include validation of credentials, continuing education, and criminal background check policy
   17. Policy for ensuring recipient's freedom of choice among providers

b. Submit a copy of the agency's organizational chart.

c. Submit a copy of the agency's proposed recipient satisfaction survey.

d. Meet all the criteria stated below.
   1. Have a physical business site at the time of application

      Note: This site cannot be an employee's home or car.

2. Have a list of potential community resources for the entire proposed service area
3. Be incorporated, unless it is a local government unit
4. Successfully complete a pre-certification site visit
5. Possess all applicable state or federal licensure, certification, and accreditation requirements
6. Employ qualified and trained case managers and supervisors who meet the qualifications as described in **Sections 6.3** and **6.4**

Incomplete applications will be returned to the provider with no further action required by DMA/DPH.

Enrollment applications are available on DMA's Web site at http://www.ncdhhs.gov/dma/provenroll.htm.

6.2.2 Recertification

The recertification is valid for up to four years. To be recertified, a provider shall

a. submit a complete and signed application to DMA within the specified time frame and
b. submit copies of all items in **Section 6.2.1** that have changed since the initial certification.

Incomplete applications will be returned to the provider with no further action required by DMA/DPH.

6.2.3 Site Visits

6.2.3.1 Technical Assistance Site Visits for New Agencies

A newly certified agency will be provided with a technical assistance (TA) site visit, to be completed approximately three months after the agency is certified. A TA site visit may also be provided for routine monitoring and/or to investigate complaints. The initial TA site visit is initiated by DMA/DPH after the agency is certified and has admitted a recipient for MCCP services. The purposes of the initial TA visit are to ensure that the agency is completing the core service components of case management according to the DMA MCCP policy and to provide training and consultation. After the initial visit, TA site visits can be provided when requested by the provider agency.

6.2.3.2 Biennial Record Review Site Visits

Biennial record reviews will be conducted starting one year from the initial date of certification. These record reviews will be conducted to

a. ensure adherence to DMA MCCP policy and
b. ensure appropriate documentation of required services stated in the DMA MCCP policy

If unmet program requirements are noted during any site visits, the provider shall submit a written corrective action plan to DMA/DPH

within 30 days. Upon review of the corrective action plan, technical assistance visits may be scheduled as deemed necessary by DMA/DPH to determine if correction action has taken place

Note: A referral to DMA Program Integrity will be made if DMA/DPH staff determine that the agency has hired non-qualified staff or if fraudulent billing is suspected.

6.2.4 Decertification

If any one of the following conditions is substantiated, the provider may be decertified by DMA/DPH and disenrolled by DMA.

a. Failure to meet the case management needs of the recipient
b. Suspected fraudulent billing practices
c. Failure to develop, submit, and implement a written plan of correction to resolve unmet program requirements cited by DMA/DPH and/or to make DMA/DPH-recommended corrections
d. Falsification of records
e. Violation of a recipient's confidentiality
f. Employment of staff who do not meet the criteria stated in **Section 6.3**
g. Failure of staff to attend the DMA/DPH mandatory basic training within six months of their employment date
h. Failure of staff to obtain required continuing educational units (CEU), as specified in **Section 6.4**
i. Failure to provide case management staff with supervision to meet the recipients' needs and to comply with all applicable state and federal rules and regulations and this policy
j. Failure to submit any required documentation within the time frame designated by this policy and/or DPH
k. Failure to implement and enforce a quality assurance program
l. Failure to notify DMA/DPH of any changes in agency name, director/ownership, case manager or supervisor, mailing address, and telephone number(s), e-mail address, resulting in DPH's or DMA's inability to contact the agency
m. Failure to comply with all applicable federal and state laws, regulations, state reimbursement plan, and policies governing the services authorized under the Medicaid program

Note: When a provider agency is decertified by DMA/DPH, due process/appeal rights shall be issued to the provider agency.

6.3 Staffing Qualifications

It is the responsibility of the provider agency to verify all staff qualifications for their staff's provision of service. A copy of the verification must be maintained by the provider.

DRAFT

6.3.1 Maternity Care Coordinator

An MCC shall meet **one** of the following qualifications:

a. Hold a master's degree from an accredited school of social work.

b. Hold a bachelor's degree from an accredited school of social work.

c. Hold a bachelor's degree from an accredited college or university in a human services field plus one year directly related experience in the areas of case management, assessment and referral, supportive counseling, intervention, psycho-social therapy and treatment planning.

d. Hold a bachelor's degree from an accredited college or university plus two years directly related experience in the areas of case management, assessment and referral, supportive counseling, intervention, psycho-social therapy and treatment planning.

e. Be licensed in the State of North Carolina as a registered nurse with a minimum of one year of experience working with pregnant women and families.

Note: A standard year of work experience is calculated at 2080 hours per calendar year. An accredited school of social work is one that is accredited by the Council on Social Work Education http://www.cswe.org. An accredited educational institution is one that is nationally recognized. Refer to a regional accreditation organization or the U.S. Department of Education Web site at http://www.ed.gov.

6.3.2 MCCP Supervisor

An MCCP supervisor shall meet **one** of the following qualifications:

a. Hold a master's degree from an accredited school of social work plus one year directly related experience in the areas of case management, assessment and referral, supportive counseling, intervention, psycho-social therapy and treatment planning.

b. Hold a bachelor's degree from an accredited school of social work plus two years experience in the areas of case management, assessment and referral, supportive counseling, intervention, psycho-social therapy and treatment planning.

c. Hold a bachelor's degree from an accredited college or university in a human services field plus either three years directly related experience in the areas of case management, assessment and referral, supportive counseling, intervention, psycho-social therapy and treatment planning or two years of experience in the aforementioned areas plus one year of supervisory experience.

d. Hold a bachelor's degree from an accredited college or university plus three years directly related experience in the areas of case management, assessment and referral, supportive counseling, intervention, psycho-social therapy, and treatment planning.

e. Be licensed in the State of North Carolina as a registered nurse with a minimum of either three years of experience working with children and families or two years experience working with children and families plus one year of supervisory experience.

Note: The agency shall identify the MCCP supervisor within the organization.

6.3.3 Maternal Care Workers

An MCW shall meet **all** of the following qualifications:

a. hold a high school diploma or equivalent;

b. be employed by an approved N.C. Medicaid–enrolled provider;

c. be certified as a Baby Love Maternal Care Worker; and

d. work under the supervision of an MCC as defined in **Section 6.2.1** to conduct the case management activities they have been certified to perform.

6.3.4 Supervision

Supervision of the individual defined as an MCW includes, but is not limited to, the following requirements: timely access to supervisor for consultation and documentation of monthly conferences to review the records of participant(s). When necessary, MCWs are expected to seek consultation with their supervising MCC, however, conferences must take place on a monthly basis, at a minimum, and must be documented in the narrative notes by the supervising MCC.

Note: MCCP services will not be covered if student interns provide the services.

6.4 Provider Training

Completion of state-sponsored, program-specific basic policy training is mandatory for all MCCP staff who provide MCCP services to Medicaid-eligible participants.

It is the responsibility of MCCP staff to retain copies of current Certificates of Completion issued by the Division of Medical Assistance (DMA). DMA is not responsible for maintaining copies or records of certification.

6.4.1 Training for New Employees

All **new** MCCP staff must complete the New Employee Basic Policy Training **prior to providing services to participants and submitting claims to Medicaid** for MCCP services. This Web-based training can be found on the DMA's Web site at http://www.ncdhhs.gov/dma/babylove.html.

Note: New MCCP staff must contact DMA if they have any questions about state policy once the training is finished.

All new employees must also participate in state-sponsored, program-specific, face-to-face training within six months of hire. The seminar schedule and registration information are available on DMA's Web site http://www.ncdhhs.gov/dma/babylove.html. Face-to-face, New Employee Basic Policy Training will be offered three times annually.

MCCP staff must complete training and be recertified if they have not functioned in that role for more than two years.

6.4.2 Supervisory Training

All MCC supervisors are required to attend state-sponsored, program-specific supervisory training. All supervisory training will be conducted jointly by DMA and DPH. Once the initial training is completed, subsequent training will be conducted when deemed necessary.

Note: Seminar schedules and registration information are published in the general Medicaid bulletins. N.C. Medicaid bulletins are available on DMA's Web site at http://www.ncdhhs.gov/dma/bulletin.htm.

6.4.3 Annual Training

It is strongly recommended that all MCCs, MCWs, and supervisors annually attend at least 10 hours of continuing education related to MCCP case management. It is the responsibility of providers to retain copies of certificates of completion.

7.0 Additional Requirements

7.1 Data Collection and Reporting

The MCCP staff is responsible for completing a MCCP Intake Screening form (DHHS T1513) for each participant at the commencement of care coordination services. This form must be completed so that intake data can be collected for every participant. The MCCP Screening Intake form (DHHS T1513) must be submitted through the Health Services Information System (HSIS) within 30 days of intake screening.

In order to collect birth outcomes data, the MCCP staff is responsible for completing a Pregnancy Outcome Summary Form (DHHS T1514) for each participant upon the completion of care coordination services. The Pregnancy Outcome Summary form (DHHS T1514) must be submitted through HSIS within 30 days of case closure.

Non–health department provider agencies (e.g., Federally Qualified Health Centers, Rural Health Clinics, physicians) who do not have access to HSIS must complete the MCCP Intake Screening (DHHS T1513) and Pregnancy Outcome Summary (DHHS T1514) forms and submit them to the address below within 30 days of case closure.

Baby Love Program
Division of Public Health
Women's Health Branch
1929 Mail Service Center
Raleigh NC 27699-1929

7.2 Medical Record Documentation

At a minimum, the participant's record must include the following documentation:

a. Completed MCCP Intake Screening form (DHHS T1513)
b. Letter of Agreement (DMA-3004) signed by both the MCC and the participant
c. MCCP Family Strengths and Needs Assessment (DMA 2007) completed by the MCC
d. MCCP Care Plan (DMA 2009) completed and updated by the MCC:

1. Care plan concerns addressed during the contact and the actions to be taken by the participant and MCCP staff before the next contact
2. Modifications to the original care plan initialed by the MCC
3. Verification that a copy of the care plan was sent to the participant's prenatal care provider

e. Narrative notes (DMA 2008) including the following components:

1. Date(s) of participant contact/attempt (service)
2. Place of service of participant contact
3. Type of contact (face-to-face, exchange of information by telephone/letter)
4. Actions taken from previous contacts/problems resolved
5. Next scheduled contact
6. Total service time component (ex: 35 minutes = 2 units)

Note: Documentation of units only is not acceptable. MCCP staff cannot round up when determining units of service rendered.

f. Name of provider agency

g. Copy of the completed Pregnancy Outcome Summary form (DHHS T1514)

h. The original signature of the designated MCCP staff is required on the following:

1. MCCP Intake Screening form (DHHS T1513)
2. Letter of Agreement (DMA-3004)
3. MCCP Initial Assessment form(DMA 2007)
4. MCCP Care Plan (DMA 2009)
5. Pregnancy Outcome Summary (DHHS T1514)
6. Narrative Sheet (DMA 2008) for each date of contact

Documentation of contacts must occur on the Care Coordination Narrative Notes (DMA 2008) or the MCCP Care Plan form (DMA 2009).

Note: An original signature is defined as a signature written by MCCP staff on the date of service or the date the form is filled out. A form is not considered complete without the required signature(s).

Note: Time spent preparing and completing documentation (i.e., completing the assessment form, writing the care plan, and the documentation activities for participant records) is not coverable.

7.3 Records Retention

As a condition of participation, providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid program [Social Security Act 1902(a)(27) and 42 CFR 431.107]. Records must be retained for a period of at least five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements (10A NCAC 22F.0107).

Copies of records must be furnished upon request.

The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).

DRAFT

7.4 State and Federal Requirements

All providers must comply with all applicable federal and state laws and regulations.

7.5 Coordination of Care

MCCP services cannot be covered when provided on the same date as the following services:

a. Home Visit for Postnatal Assessment and Follow-Up Care
b. Maternal Care Skilled Nurse Home Visit

If a Health and Behavior Intervention (HBI) visit is determined to be necessary during an MCC home visit, both services can be covered on the same day. Health and Behavior Intervention must be performed by a HBI staff member who, according to DMA Clinical Coverage Policy #1M-3, *Health and Behavior Intervention*, is qualified to render the service and clearly understands the difference between HBI and MCCP.

7.6 Program Monitoring

All MCCP provider agencies must implement a mechanism to monitor the program. This monitoring must include, but is not limited to, the following:

a. Implementing a mechanism to determine staff knowledge and understanding of service delivery and how the participant utilizes the program; for example, verification of education and certifications, development of an orientation process and assessment of staff knowledge via oral/written test, interview and observation by the supervisor
b. Maintaining or accessing documentation of quality assurance file and personnel file, including staff qualifications, education and work experience, required trainings, and licensure or certification, if applicable
c. Implementing the orientation and training plan and a method for regularly scheduled evaluations
d. Implementing an internal quality assurance policy and plan for semi-annual record review of all MCCP staff, including, at a minimum, the name of the person who is responsible for the quality assurance program; the method for sampling records; the procedure for developing a corrective action plan for identified problems; the procedure for follow-up to ensure that identified problems have been corrected; the procedure for evaluating participant satisfaction (e.g., consumer satisfaction surveys); and the procedure for processing complaints
e. Ensuring that problems identified through the quality improvement plan, which cause monetary overpayment, are reported to DMA
f. Participating in community collaboration with MCCP service delivery [for example, attending health fairs, becoming a member of multipurpose collaborative bodies (boards), developing partnerships with other community agencies that provide valuable services to the population served]
g. Ensuring staff attendance at mandatory state-sponsored trainings, as appropriate

7.7 Service Summary

To ensure the program's success, the MCCP staff requirements include but are **not limited** to

a. Explaining MCCP services to the participant
b. Informing the participant that all information is kept confidential except for situations of clear and imminent danger, which must be reported to the appropriate authority
c. Completing the MCCP Intake Screening form (DHHS T1513)
d. Obtaining the participant's signature on the MCCP Letter of Agreement form (DMA-3004)
e. Completing the MCCP Strengths/Needs Assessment form (DMA 2007)
f. Developing a Care Plan (DMA 2009) based on the participant's needs and concerns, with provider and program needs and concerns documented separately
g. Helping the participant select a primary care provider and/or prenatal care provider
h. Assisting the participant in planning visits to providers and coordinating
i. Providing transportation services when needed
j. Collaborating with providers, especially prenatal care providers, to make sure the care plan is followed and revised, if necessary
k. Monitoring participant's ongoing care coordination, making referrals, and updating the participant's care plan, as necessary
l. Referring the participant to the WIC program
m. Providing appropriate resource information to participants
n. Closing participant cases, including completing the Pregnancy Outcome Summary form (DHHS T1514)
o. Assisting the participant with transitioning from MCCP

Note: All of the forms referred to in this policy can be obtained either from DMA's Web site at http://www.ncdhhs.gov/dma/forms.html or the Division of Public Health Web site at http://wch.dhhs.state.nc.us/whs.htm.

8.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 2002

Revision Information:

Date	Section Revised	Change
9/1/05	Section 2.0	A special provision related to EPSDT was added.
9/1/05	Section 8.0	Text stating that providers must comply with Medicaid guidelines was added to Section 8.0.
12/1/05	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
12/1/06	Sections 2 through 4	A special provision related to EPSDT was added.

DRAFT

Date	Section Revised	Change
5/1/07	Sections 2 through 4	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
	Section 1.0	The description of the service was revised to include information on voluntary participation, care coordination and define the roles of the MCW and MCC.
	Section 3.3	Criteria for approval of additional billing units were expanded to include the postpartum period.
	Section 4.2	This section was added to address non-covered services.
	Section 5.0	This section was expanded to clarify the responsibilities of MCCP staff. The definitions of case management and targeted case management were also added.
	Section 5.1	This section was added to establish when a one-on-one, face-to-face visit should be conducted.
	Section 5.1.1	Full descriptions were added for listed codes.
	Section 5.3.1	This section was revised to address the assessment component of the service.
	Section 5.3.2	This section was revised to clarify the MCC's responsibilities regarding care planning.
	Section 5.3.3	This section was expanded to address activities associated with the referral and linkage component of the service.
	Section 5.3.4	This section was expanded to address case monitoring and follow-up visits.
	Section 5.4	This section was added to address case conferencing.
	Section 5.8	This section was expanded to address activities associated with the postpartum period.
	Section 5.9	This section was expanded to clarify when service should be closed.
	Section 5.10	This section was expanded to clarify the Transfer section of the service.
	Section 6.0	The list of eligible providers was revised to clarify who could provide service.
	Section 6.1	This section was expanded to include certification of provider agencies.
	Section 6.2.3.2	Changed "bi-annual" to "biennial."
	Section 6.3	Staffing qualifications were redefined.
	Section 6.4	Requirements for provider training were added.
	Section 7.1	Requirements for data collection and reporting were clarified.

DRAFT

Date	Section Revised	Change
	Section 7.2	Documentation requirements were revised to include copies of assessments, care plan, screening tools, narrative notes and the outcome summary as a part of the recipient's record. The title of the section was changed to Medical Record Documentation.
	Section 7.3	This section was added to address record retention.
	Section 7.4	This section was added to require compliance with applicable laws and regulations.
	Section 7.6	Requirements for program monitoring were added; updated form numbers.
	Section 8.1	Section 8.1 was reformatted as item A in Attachment A.
	Section 8.2	Section 8.2 was reformatted as item B in Attachment A and the list of diagnosis codes that support medical necessity was revised.
	Section 8.3	Section 8.3 was reformatted as item C in Attachment A.
	Section 8.4	Section 8.4 was reformatted as item H in Attachment A.
	Attachment A, Item D	Information related to modifiers was added as item D in Attachment A.
	Attachment A, Item E	Information related to billing units was added as item E in Attachment A
	Attachment A, Item F	Information related to the place of service was added as item F in Attachment A.
	Attachment A, Item G	Information related to copayment requirements was added as Item G in Attachment A.
	Attachment B	This attachment was added to the policy to provide samples of related forms.

DRAFT

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

B. Diagnosis Codes That Support Medical Necessity

Providers must bill the ICD-9-CM diagnosis codes to the highest level of specificity that supports medical necessity.

Codes	Description
V22.0	Normal pregnancy; Supervision of normal first pregnancy
V22.1	Normal pregnancy; Supervision of other normal pregnancy
V23.0	Supervision of high-risk pregnancy; Pregnancy with history of infertility
V23.1	Supervision of high-risk pregnancy; Pregnancy with history of trophoblastic disease
V23.2	Supervision of high-risk pregnancy; Pregnancy with history of abortion
V23.3	Supervision of high-risk pregnancy; Grand multiparity
V23.41	Pregnancy with other poor obstetric history; Pregnancy with history of pre-term labor
V23.49	Pregnancy with other poor obstetric history; Pregnancy with other poor obstetric history
V23.5	Pregnancy with other poor obstetric history; Pregnancy with other poor reproductive history
V23.7	Pregnancy with other poor obstetric history; Insufficient prenatal care
V23.81	Other high-risk pregnancy; Elderly primigravida
V23.82	Other high-risk pregnancy; Elderly multigravida
V23.83	Other high-risk pregnancy; Young primigravida
V23.84	Other high-risk pregnancy; Young multigravida
V23.89	Other high-risk pregnancy; Other high-risk pregnancy
V23.9	Other high-risk pregnancy; Unspecified high-risk pregnancy
V24.0	Postpartum care and examination; Immediately after delivery
V24.2	Postpartum care and examination; Routine postpartum follow-up

C. Procedure Code(s)

1. **Maternity Care Coordinator**
   HCPCS code T1017—Targeted case management, each 15 minutes
2. **Maternal Care Worker**
   HCPCS code T1017—Targeted case management, each 15 minutes

D. Modifiers

1. **Maternity Care Coordinator**
   Services provided by a MCC are billed without a modifier.
2. **Maternal Care Worker**
   Services provided by a MCW are billed with the HM (less than a bachelor degree) modifier appended to the HCPCS procedure code.

DRAFT

E. Billing Units

MCCP services are reimbursed per unit; each unit equals 15 minutes. MCCP services must be billed per date of service.

F. Billing Guidelines

Services provided by the MCC are covered for up to six units (90 minutes) per month for the following ICD-9-CM diagnosis codes:

Codes	Description
V22.0	Normal pregnancy; Supervision of normal first pregnancy
V22.1	Normal pregnancy; Supervision of other normal pregnancy
V23.0	Supervision of high-risk pregnancy; Pregnancy with history of infertility
V23.1	Supervision of high-risk pregnancy; Pregnancy with history of trophoblastic disease
V23.2	Supervision of high-risk pregnancy; Pregnancy with history of abortion
V23.7	Pregnancy with other poor obstetric history; Insufficient prenatal care
V23.9	Other high-risk pregnancy; Unspecified high risk pregnancy
V24.0	Postpartum care and examination; Immediately after delivery
V24.2	Postpartum care and examination; Routine postpartum follow-up

Services provided by the MCC are covered for up to eight units (120 minutes) per month for the following ICD-9-CM diagnosis codes:

Codes	Description
V23.3	Supervision of high-risk pregnancy; Grand multiparity
V23.41	Pregnancy with other poor obstetric history; Pregnancy with history of pre-term labor
V23.49	Pregnancy with other poor obstetric history; Pregnancy with other poor obstetric history
V23.5	Pregnancy with other poor obstetric history; Pregnancy with other poor reproductive history
V23.81	Other high-risk pregnancy; Elderly primigravida
V23.82	Other high-risk pregnancy; Elderly multigravida
V23.83	Other high-risk pregnancy; Young primigravida
V23.84	Other high-risk pregnancy; Young multigravida
V23.89	Other high-risk pregnancy; Other high-risk pregnancy

Services provided by the MCW are covered for up to seven units (105 minutes) per month.

Coverage of additional units will be considered only when conditions of coverage are met and documentation supports the necessity factors (or high-risk criteria) indicated in **Section 3.3.** Additional units may be requested through the claims adjustment process for services rendered by the MCC.

G. Place of Service

This service can be rendered at a clinic/office, home, or a mutually agreeable site for the MCCP staff and the participant.

H. Co-Payments

This service does not require a co-payment.

DRAFT

I. Reimbursement Rate

Providers must bill their usual and customary charges.

DRAFT

Attachment B: Program Forms

The following forms are available on the DMA Forms Web page (http://www.ncdhhs.gov/dma/formsprov.html#babylove). Images are provided here for reference.

A. Intake Screening, DHHS T1513 (formerly DMA-2006)

1. Last name First name MI

2. Patient Number -- H

3. Date of Birth MM DD YY

4. Race (Check all that apply.) ☐ 1=White ☐ 2=Black ☐ 3=Am. Indian/Alaskan Native ☐ 4=Asian/Pacific Islander ☐ 5=Native Hawaiian/Other Pacific Islander ☐ 6=Unknown

Ethnicity: Hispanic or Latino Origin? ☐ 1=Yes ☐ 2=No ☐ 3=Unknown

5. Sex ☒ 2=Female

6. County of Residence

Medicaid Number

Medicaid Type ☐ 1=Blue ☐ 2=Pink (MPW) ☐ 3=PE only ☐ 4=None

N.C. Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

MATERNITY CARE COORDINATION PROGRAM INTAKE SCREENING

(See Instructions)

Date of Intake Screening MM DD YY

Verification of Pregnancy ☐ 1=Copy of positive pregnancy test ☐ 2=Copy of current month MPW card ☐ 3=Child's birth/death certificate ☐ 4=Provider verification of pregnancy loss ☐ 5=None available

/ / MM/DD/YY Date of Last Menstrual Period

/ / MM/DD/YY Due Date or N/A if postpartum ☐

__ Weeks gestation at screening or N/A if postpartum ☐

Pregnancy Intendedness (Check one.) ☐ 1=Wanted to be pregnant sooner ☐ 2=Wanted to be pregnant later ☐ 3=Wants to be pregnant now ☐ 4=Did not want to be pregnant now or at any time in the future ☐ 5=Doesn't know ☐ 6=Declined answering

Family Planning - Using any birth control method when became pregnant. (Check one.) ☐ 1=Yes ☐ 2=No ☐ 3=Doesn't know ☐ 4=Declined answering

Pregnancy History

Number of pregnancies, including this one __

Date last pregnancy ended / / MM/DD/YY or N/A ☐

Prenatal Care

☐ 1=Receiving prenatal care ☐ 2=Not yet in prenatal care ☐ 3=Declined answering

__ Number of weeks gestation when prenatal care began *(Leave blank if not yet in prenatal care or declined answering.)*

WIC Status ☐ 1=Referred, but not yet receiving ☐ 2=Receiving ☐ 3=Declined ☐ 4=Ineligible

Maternal Intake Data

___ lbs. Pre-pregnancy weight

_ feet __ inches Height without shoes

__._ Pre-pregnancy Body Mass Index (BMI)

BMI = Weight in Pounds / (Height in inches) x (Height in inches) x 703

Instructions for the Maternity Care Coordination Program Intake Screening (MCCP-IS)

Purpose: To collect data on Maternity Care Coordination Program client status at the initial MCCP contact.

Preparation: 1. Complete form, entering all required data. 2. Submit data into HSIS. 3. File original form in client's medical record.

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Historical Resources.

Additional forms may be ordered using the Requisition for Maternal Health Materials form (DHHS 3980), available at http://wch.dhhs.state.nc.us/whs.htm.

DHHS T1513 (Revised 4/23/07)
Women's Health (Review 4/08)

Page 1 of 2

DRAFT

Last name	First name	MI	Date of Birth / / MM/DD/YY

Psychosocial Risks/Needs Identified at Screening (Check all that apply.)

- ☐ Medicaid Participation
- ☐ Adequate Prenatal Care
- ☐ Medical Home for Self or Family
- ☐ Family Planning
- ☐ Interpreter Services
- ☐ Support System
- ☐ Transportation
- ☐ Employment
- ☐ School Enrollment or GED
- ☐ Child Care
- ☐ Financial Resources
- ☐ Nutritional Counseling
- ☐ Food Assistance
- ☐ Breastfeeding/Infant Feeding
- ☐ Parenting Information
- ☐ Adequate or Safe Housing
- ☐ Smoking Cessation
- ☐ Substance Use
- ☐ Mental Health or Behavioral Health
- ☐ Domestic Violence
- ☐ Sexual Abuse
- ☐ _____ *Local Use/Demonstration*

Medical Risks Identified at Screening (Check all that apply.)

- ☐ Previous premature/preterm delivery (<37 weeks)
- ☐ Previous low birthweight baby (5.5 lbs or less)
- ☐ Previous abortion(s) or miscarriage(s)
- ☐ Previous stillbirth
- ☐ Ectopic or molar pregnancy (current or previous)
- ☐ Pregnancy with congenital anomaly (current or previous)
- ☐ Obstetrical problems (current or previous)
- ☐ Multiple pregnancy (current)
- ☐ History of infertility
- ☐ Uterine or cervical abnormalities
- ☐ Vaginal bleeding
- ☐ Recurring UTIs/STIs/Vaginal infections
- ☐ High blood pressure/hypertension
- ☐ Diabetes
- ☐ Gestational diabetes
- ☐ Anemia or sickle cell disease
- ☐ Asthma
- ☐ Heart, kidney, or lung problems
- ☐ Prescription medication

For items below, transfer results from Page 1.

- ☐ Currently age 35 or older
- ☐ Currently age 17 or younger
- ☐ Short interconceptional interval (<6 months)
- ☐ Late entry to prenatal care (after 1st trimester)
- ☐ Pre-pregnant BMI below 19.8 (underweight)
- ☐ Pre-pregnant BMI 26.1-29.0 (overweight)
- ☐ Pre-pregnant BMI above 29.0 (obese)

Maternity Care Coordination Program Information

Enrolled in MCCP? ☐ 1=Yes ☐ 2=Declined ☐ 3=Not Eligible

Name and signature of Maternity Care Coordinator completing form:

Print name: _____

Signature: _____ Date: ___/___/___

Participant Information:

I understand that *I am eligible* to receive Maternity Care Coordination services, and *I wish to participate in the program.*

Print name: _____

Signature: _____ Date: ____/____/____

I understand that *I am eligible* to receive Maternity Care Coordination services, but *I do not want* these services.

Print name: _____

Signature: _____ Date: ____/____/____

I understand that *I am not eligible* to receive Maternity Care Coordination services, and my appeal rights have been explained.

Print name: _____

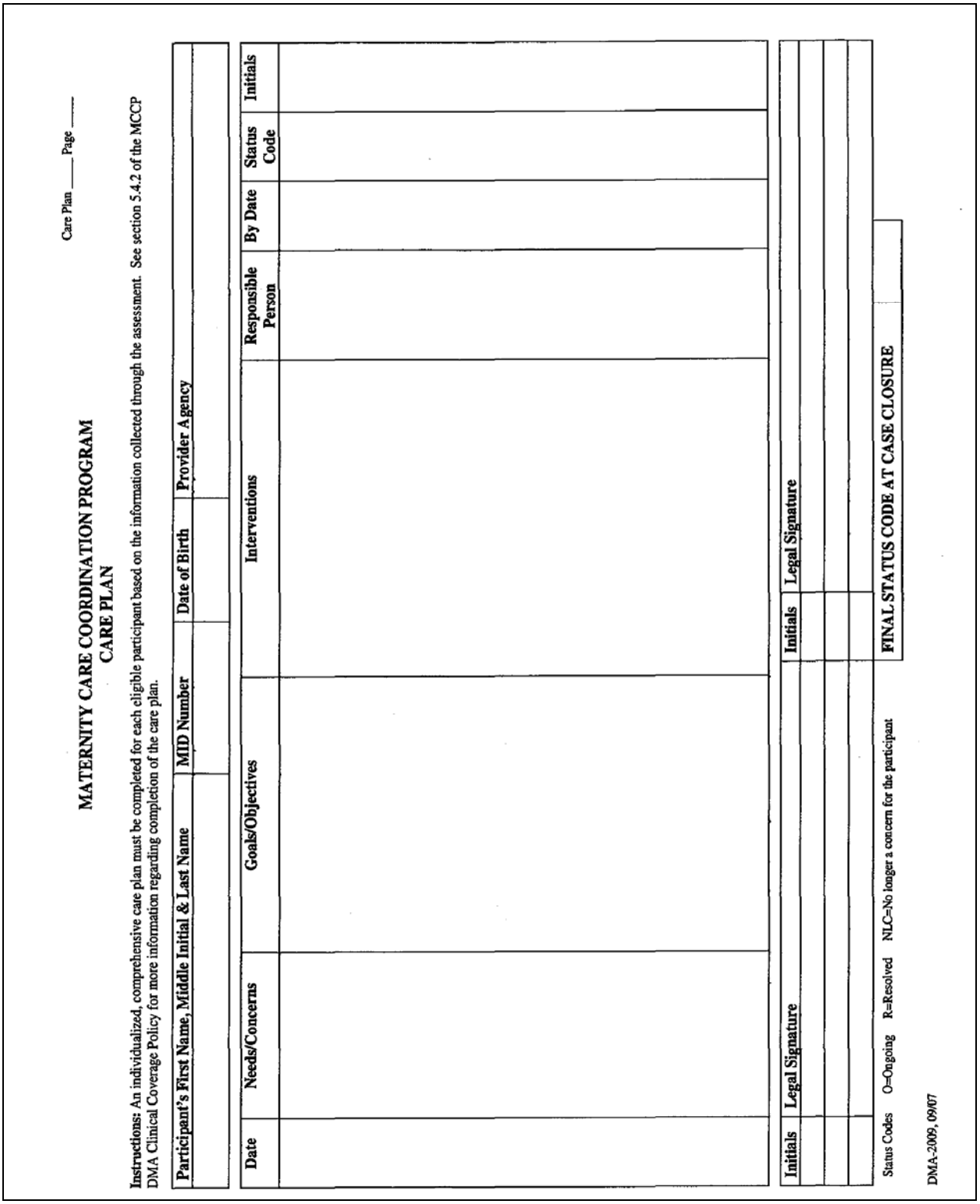
Signature: _____ Date: ____/____/____

DHHS T1513 (Revised 4/23/07)
Women's Health (Review 4/08)

Page 2 of 2

DRAFT

B. Care Plan, DMA 2009



Care Plan ____ Page ____

MATERNITY CARE COORDINATION PROGRAM
CARE PLAN

Instructions: An individualized, comprehensive care plan must be completed for each eligible participant based on the information collected through the assessment. See section 5.4.2 of the MCCP DMA Clinical Coverage Policy for more information regarding completion of the care plan.

Participant's First Name, Middle Initial & Last Name	MID Number	Date of Birth	Provider Agency

Date	Needs/Concerns	Goals/Objectives	Interventions	Responsible Person	By Date	Status Code	Initials

Initials	Legal Signature	Initials	Legal Signature

Status Codes O=Ongoing R=Resolved NLC=No longer a concern for the participant

FINAL STATUS CODE AT CASE CLOSURE

DMA-2009, 09/07

DRAFT

C. Letter of Agreement, DMA-3004

NC Maternity Care Coordination Program
Letter of Agreement

The Baby Love Medical Assistance Program wants you to have a healthy baby. Your Maternity Care Coordinator (MCC) can help you find and get the services you need. Your MCC is there to help you and can provide you with information about:

- Medical benefits
- Prenatal care
- WIC Services
- Transportation
- Information about pregnancy
- Information about other services

Your part in care coordination services is to:

- Get prenatal care and WIC as soon as possible
- Keep all appointments
- Tell your MCC about your needs during pregnancy
- Let your MCC know how and where you would like to be contacted
- Do your best to follow your plan for having a healthy baby

Both the MCC and the participant must agree to sign this Letter of Agreement to begin MCCP services.

PARTICIPANT
I understand my part and wish to get Maternity Care Coordination Program (MCCP) services. Prenatal care, Medicaid benefits and other services will not stop if I decide not to participate. I understand that I may withdraw from this program at any time.

Participant's Signature _____ Date _____ Printed Name of Participant _____

MATERNITY CARE COORDINATOR
I understand my role in the Maternity Care Coordination Program, and will work with the client to help her receive the services she needs.
I have provided the participant with information regarding MCCP and the role of the MCC
☐ Yes ☐ No
I have provided the participant with a copy of this Letter of Agreement
☐ Yes ☐ No

Maternity Care Coordinator's Signature _____ Date _____ Printed name of MCC _____

Agency _____ Telephone _____

Instructions: The Letter of Agreement must be completed during enrollment – See Section 5.3.1.2.Enrollment, in the DMA MCCP Clinical Coverage Policy.

DMA-3004 Rev. 09/07

DRAFT

D. Family Strengths and Needs Assessment, DMA 2007

1. Last name First name MI	**MATERNITY CARE COORDINATION PROGRAM FAMILY STRENGTHS AND NEEDS ASSESSMENT**
2. Patient Number -- H	
3. Date of Birth Month Day Year	**MCC Provider Agency** _____
4. Race (Check all that apply.) ☐ 1= White ☐ 2= Black ☐ 3= Am. Indian/Alaskan Native ☐ 4= Asian/Pacific Islander ☐ 5= Native Hawaiian/Other Pacific Islander ☐ 6= Unknown Ethnicity: Hispanic or Latino Origin? ☐ 1=Yes ☐ 2=No	**Date of Initial Assessment** Month Day Year
5. Sex ☒ 2= Female	
6. County of Residence	Presumptive Eligibility Period: Start Date End Date
Medicaid Number	Medicaid Type ☐ 1=Blue ☐ 2=Pink (MPW) ☐ 3=PE only ☐ 4=None

Address:
Directions to Home:
If moves, new address:
Directions to Home:
Home Phone: Cell Phone: Work Phone:

Other Contact Name: Phone:
Gravida/Parity_____

Household Members:
Name/Relationship/Age

Risk/Need Xxyee Oxno	Medical/Psychosocial Risks and Client Needs	Comments/Notes (Including Strengths/Resources)
	1. Medicaid Participation ☐ Assess Medicaid eligibility. ☐ Discuss benefits of Medicaid eligibility. ☐ Provide information on automatic newborn eligibility or newborn application process for Medicaid-ineligible women.	Medicaid caseworker_____
	2. Adequate Prenatal Care ☐ Provide information about early and continuous prenatal care. ☐ Verify that client has received printed information about pregnancy. ☐ Assess relationship with prenatal care provider. ☐ Provide information on childbirth education. ☐ Review signs and symptoms of preterm labor. **Concern about Pregnancy** ☐ Assess current feelings about pregnancy. **Previous Pregnancy Experience** ☐ Assess past pregnancy experience.	Prenatal Care Provider _____
	3. Medical Home for Self or Family **Health Care of Mother** ☐ Identify any non-pregnancy related medical or psychiatric concerns. ☐Inquire if client had a primary care provider prior to pregnancy. **Health Care of Child** ☐ Determine if client's children have a local health care provider and status of their immunizations. ☐Determine if client has a health care provider for newborn. **Health Care of Family** ☐ Assess health status of family members. ☐ Assess household members for up-to-date immunizations.	Primary Care Provider _____

DMA 2007 (9/07)
Review (9/08)

Page 1 of 4

DRAFT

Last name	First name	MI	Date of Birth / / MM/DD/YY
	4. Family Planning ☐ Assess previous use of birth control methods. ☐ Explore positive/negative feelings regarding specific birth control methods. ☐ Provide information on the Family Planning Waiver.		
	5. Interpreter Services/Cultural Issues ☐ Determine if the client needs interpreter/translation services. If yes, assess if these services are being received. What language do you prefer to speak? What language do you prefer to use for reading? ☐Determine if client has any concerns or conflicts with delivery of care based on their religion, ethnic background, or culture. ☐ Allow client to express religious, ethnic or cultural preferences and beliefs.		
	6. Support System ☐ Discuss plans for labor and delivery ☐ Explain significance of social support. ☐ Assess client's support system and current relationships. ☐ Further assess who she can depend on for support, now, for labor and delivery, and after the baby is born.		☐Single ☐Separated ☐Widowed ☐Divorced ☐Married ☐Cohabiting
	7. Transportation ☐ Determine reliability/dependability of client's transportation. ☐ Assess current barriers with transportation. ☐Assess transportation to hospital for labor and delivery. ☐ Assess use of seatbelts. ☐ Assess car seat availability for baby/children.		
	8. Employment ☐ Determine client's work status. ☐ If not employed, explore interest in gaining employment. ☐ If employed, inquire about plans to work during and after pregnancy. ☐ Identify place of employment and work schedule. ☐ Discuss potential work hazards that might effect pregnancy outcomes.		☐Full Time ☐Part Time ☐Work First ☐Not Working Current Employer: _____
	9. Education ☐ Determine highest level of education completed. ☐ Assess career and education goals. ☐ Assess ability and motivation to complete high school education. ☐ Assess previous school experiences. ☐ Discuss potential barriers, if client is interested in resuming her education.		☐Student Current School:_____
	10. Child Care ☐ Assess current and future need for child care.		
	11. Financial Resources ☐ Assess client's ability to meet their financial needs and obligations. ☐ Assess financial support from father of the baby. ☐ Assess eligibility for public assistance or other assistance programs. ☐ Assess client's ability to obtain needed baby items.		
	12. Nutrition and Health ☐ Provide information on gestational weight gain. ☐ Assess need for additional information on healthy weight. ☐ Discuss other nutrition and health needs or goals.		
	13. WIC Participation/Food Assistance ☐ WIC Discussed ☐ Explain the benefits of WIC Program for client and children. ☐ Assess potential eligibility for WIC Program. ☐ Assess potential eligibility for Food Stamps and/or emergency food assistance.		WIC enrolled __ WIC referred __

DMA 2007 (9/07)
Review (9/08)

Page 2 of 4

DRAFT

Last name	First name	MI	Date of Birth / / MM/DD/YY

	14. Breastfeeding/Infant Feeding Options ☐ Assess if client has previous experience with a specific infant feeding method. ☐ Inquire if client has considered a specific feeding method. ☐ Ask client to consider partner's views regarding feeding method. ☐ Ensure client has considered pros and cons of both feeding methods.	
	15. Parenting Information ☐ Discussed parenting education ☐ Provided information on infant safety seat. ☐ Assess client's parenting experience and/or experience caring for infants/children. ☐ Inquire about father/support persons' experience and anticipated involvement. ☐ Explore issues of single parenthood, if indicated. ☐ Identify if children are living with or apart from parent(s).	
	16. Adequate and Safe Housing ☐ Explore safety and stability of current housing. ☐ Determine availability of electricity, indoor plumbing, hot and cold water, refrigerator, stove, heat and air conditioning, and telephone. ☐ Assess firearm safety. ☐ Assess infant/child safety and child proofing at home visit. ☐ Assess operating smoke alarm.	
	17. Smoking Cessation/Tobacco Use ☐ Assess smoking/tobacco use history and current usage using the first 3 of the 5 A's. ☐ "ASK" Ask about smoking status and exposure to secondhand smoke. ☐ "ADVISE" Provide clear, strong advice to quit and discuss the benefits of quitting and eliminating secondhand smoke. ☐ "ASSESS" If client currently smokes, assess her willingness to quit.	
	18. Substance Use/Abuse ☐ I ask all of my clients these questions because it is important to their health and the health of their babies. **Modified 5Ps Screening** ☐ 1. Do either of your parents have a problem with using alcohol or drugs? ☐ 2. Do any of your friends have a problem with drugs or alcohol? ☐ 3. Does your partner have a problem with drug or alcohol use? ☐ 4. Before you knew your were pregnant, how often did you drink alcohol or use drugs? ☐ 5. In the past month how often did you drink alcohol or use drugs? ☐ Further assess using medical history and observations.	1. ☐ No ☐ Yes ☐ No answer 2. ☐ No ☐ Yes ☐ No answer 3. ☐ No ☐ Yes ☐ No answer 4. ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently 5. ☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently Neg – Benefits of Abstinence Pos – Review reported info, state concern for health of mom and baby, make plan/referrals.
	19. Mental Health/Behavioral Health (Depression/Anxiety) ☐ Explain that all clients are screened for depression, anxiety, and other mental health concerns. **Depression Screening** ☐ Screen for depression and/or feelings of depression using standard screening questions or screening tools. ☐ Inquire if client had postpartum depression with previous pregnancy(ies). **Anxiety Screening** ☐ Screen for anxiety using standard screening questions or screening tools. **Mental Health** ☐ Ask client if they have ever received treatment or counseling for any emotional difficulties or mental health concerns. ☐ Explore sources of emotional/social support.	

DMA 2007 (9/07)
Review (9/08)

Page 3 of 4

DRAFT

Last name	First name	MI	Date of Birth / / MM/DD/YY

20. Domestic Violence/Sexual Abuse

☐ State, "Because violence is so common in many women's lives and because there is help for women who are being abused, I ask everyone about domestic violence."

ACOG Screening

☐ Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?

☐ Are you in a relationship with a person who threatens or physically hurts you?

☐ Has anyone forced you to have sexual activities that made you feel uncomfortable?

1st trimester screening date or N/A ☐
2nd trimester screening date or N/A ☐
3rd trimester screening date or N/A ☐
Postpartum screening date or N/A ☐

If yes, by whom? What happened?

21. Additional Strengths/Needs

Name and signature of Maternity Care Coordinator at Initial Assessment	Month	Day	Year
Print name: _____			
Signature: _____			

Reviews and Updates (Reviewed all categories. Updates noted and dated in Notes/Comments.) **Name and signature of Maternity Care Coordinator**	Month	Day	Year
Print name: _____ Signature: _____			
Print name: _____ Signature: _____			
Print name: _____ Signature: _____			
Print name: _____ Signature: _____			
Print name: _____ Signature: _____			
Print name: _____ Signature: _____			
Print name: _____ Signature: _____			
Print name: _____ Signature: _____			
Print name: _____ Signature: _____			
Print name: _____ Signature: _____			
Print name: _____ Signature: _____			
Print name: _____ Signature: _____			

DMA 2007 (9/07)
Review (9/08)

Page 4 of 4

DRAFT

E. Pregnancy Outcome Summary, DHHS T1514 (formerly DMA-3002)

1. Last name | First name | MI

2. Patient Number ____ -- H

3. Date of Birth ____ Month ____ Day ____ Year

4. Race (Check all that apply.) ☐ 1=White ☐ 2=Black ☐ 3=American Indian/Alaskan Native ☐ 4=Asian/Pacific Islander ☐ 5=Native Hawaiian/Other Pacific Islander ☐ 6=Unknown

Ethnicity: Hispanic or Latino Origin? ☐ 1=Yes ☐ 2=No ☐ 3=Unknown

5. Sex ☒ 2=Female

6. County of Residence ____

Medicaid Number ____

Medicaid Type ☐ 1=Blue ☐ 2=Pink (MPW) ☐ 3=PE only ☐ 4=None

N.C. Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

PREGNANCY OUTCOME SUMMARY

(See Instructions)

	Month	Day	Year
Date of Form Completion			
Date Pregnancy Ended or N/A ☐			
Date of MCCP Closure or N/A ☐			

Reason for Maternal Health Closure (Use only for women not enrolled in MCCP at closure. Check one.)

☐ 1=Pregnancy Ended ☐ 2=Lost to Follow-Up ☐ 3=Moved ☐ 4=Maternal Death ☐ 5=Declined Prenatal Care ☐ 6=Not Pregnant ☐ 7=Transferred to Other Provider

Reason for Maternity Care Coordination Program (MCCP) Closure (Check one.)

☐ 1=Pregnancy Ended ☐ 2=Lost to Follow-Up ☐ 3=Moved ☐ 4=Maternal Death ☐ 5=Declined MCC Services ☐ 6=Services No Longer Needed ☐ 7=Transferred to Other Provider ☐ 8=Incarcerated ☐ 9=No Longer Medicaid-Eligible

Multiple births or outcomes ☐ 1=Yes ☐ 2=No

Prenatal Care Provider (Check all that apply.) ☐ 1=Health Department ☐ 2=Private Provider ☐ 3=Rural/Community Health Center ☐ 4=Tertiary High Risk Center ☐ 5=None

Maternal Data *Enter maternal data for all pregnancy outcomes.*

__ __ Number of weeks gestation when prenatal care began *(Enter 99 if no prenatal care received.)*

__ __ Total number of prenatal visits regardless of medical provider

__ __ __ lbs. Pre-pregnancy weight

__ feet __ __ inches Height without shoes

__ __.__ Pre-pregnancy Body Mass Index (BMI)

__ __ __ lbs. Weight at last prenatal visit prior to delivery

__ __ Total prenatal weight gain

BMI = Weight in Pounds / (Height in Inches) x (Height in Inches) × 703

Referred for WIC prenatally? ☐ 1=Yes ☐ 2=No

Received WIC prenatally? ☐ 1=Yes ☐ 4=Declined ☐ 5=Ineligible

Received WIC postpartum? ☐ 1=Yes ☐ 4=Declined ☐ 5=Ineligible

Received postpartum exam/family planning exam? ☐ 1=Yes ☐ 2=No ☐ 6=Lost to Follow-up

Received method of family planning? ☐ 1=Yes ☐ 2=No ☐ 3=Unknown

DHHS T1514 (Revised 4/23/07)
Women's Health (Review 4/08)

Page 1 of 4

DRAFT

Last name	First name	MI	Date of Birth / / Month/Day/Year

Maternity Care Coordination Information

Client received Maternity Care Coordination Program (MCCP) services? *(If answer is No, Declined, Not Eligible, or Not Available, proceed to Infant Data.)*
☐ 1=Yes ☐ 2=No ☐ 3=Declined ☐ 4=Not Eligible ☐ 5=Not Available

Maternity Care Coordinator Staffing Qualification
☐ 1=Registered Nurse ☐ 2=Social Worker with social work degree ☐ 3=Social Worker with other degree

Client received Maternal Outreach Worker (MOW) services?
☐ 1=Yes ☐ 2=No ☐ 3=Declined ☐ 4=Not Eligible ☐ 5=Not Available

__ __ Weeks gestation when MCCP services began. *(Enter 99 if MCC services began postpartum.)*

__ __ Number of months client received MCCP services.

__ __ __ Number of total units of MCCP services client received.

Medical Risks Identified Since Screening (for Maternity Care Coordination Program recipients only)
Mark the appropriate code to indicate medical risk factors identified since MCCP intake screening.

☐ Ectopic or molar pregnancy (current pregnancy)
☐ Pregnancy with congenital anomaly (current pregnancy)
☐ Obstetrical problems (current pregnancy)
☐ Multiple pregnancy (current pregnancy)
☐ Uterine or cervical abnormalities
☐ Vaginal bleeding (current pregnancy)
☐ Recurring UTIs/STIs/Vaginal infections
☐ High blood pressure/hypertension
☐ Diabetes
☐ Gestational diabetes
☐ Anemia or sickle cell disease
☐ Asthma
☐ Heart, kidney, or lung problems
☐ Prescription medication
☐ Late entry to prenatal care (after 1st trimester)

Psychosocial Risks/Needs Outcomes (for Maternity Care Coordination Program recipients only)
Mark the appropriate code to indicate the outcome of the needs identified during MCCP services.

Codes:
① = Need addressed and resolved
② = Need addressed and ongoing
③ = Need not met, insufficient resources
④ = Need not met, client declined services

①②③④		①②③④	
☐☐☐☐	Medicaid Participation	☐☐☐☐	Nutritional Counseling
☐☐☐☐	Adequate Prenatal Care	☐☐☐☐	Food Assistance
☐☐☐☐	Medical Home for Self or Family	☐☐☐☐	Breastfeeding/Infant Feeding
☐☐☐☐	Family Planning	☐☐☐☐	Parenting Information
☐☐☐☐	Interpreter Services	☐☐☐☐	Adequate or Safe Housing
☐☐☐☐	Support System	☐☐☐☐	Smoking Cessation
☐☐☐☐	Transportation	☐☐☐☐	Substance Use
☐☐☐☐	Employment	☐☐☐☐	Mental Health or Behavioral Health
☐☐☐☐	School Enrollment or GED	☐☐☐☐	Domestic Violence
☐☐☐☐	Child Care	☐☐☐☐	Sexual Abuse
☐☐☐☐	Financial Resources	☐☐☐☐	_____ *Local Use/Demonstration*

DHHS T1514 (Revised 4/23/07)
Women's Health (Review 4/08)

Page 2 of 4

DRAFT

Last name First name MI	Date of Birth / / Month/Day/Year
Infant Data	
Baby A	
Pregnancy Outcome ***If live birth, complete additional fields.***	☐ 1=Live Birth ☐ 2=Spontaneous Abortion ☐ 3=Therapeutic Abortion ☐ 4=Fetal Death, >20 wks.
Gestational Age at Pregnancy Outcome	. weeks
Weight	lbs oz *or* g
Sex	☐ 1=Male ☐ 2=Female
Mother Breastfeeding?	☐ 1=Yes ☐ 2=No
Baby receiving WIC?	☐ 1=Yes ☐ 2=No
Health Check Exam or Well Child Care?	☐ 1=Yes ☐ 2=No
Referred to CSC?	☐ 1=Yes ☐ 2=No
Baby B	
Pregnancy Outcome ***If live birth, complete additional fields.***	☐ 1=Live Birth ☐ 2=Spontaneous Abortion ☐ 3=Therapeutic Abortion ☐ 4=Fetal Death, >20 wks.
Gestational Age at Pregnancy Outcome	. weeks
Weight	lbs oz *or* g
Sex	☐ 1= Male ☐ 2= Female
Mother Breastfeeding?	☐ 1=Yes ☐ 2=No
Baby receiving WIC?	☐ 1=Yes ☐ 2=No
Health Check Exam or Well Child Care?	☐ 1=Yes ☐ 2=No
Referred to CSC?	☐ 1=Yes ☐ 2=No
Baby C	
Pregnancy Outcome ***If live birth, complete additional fields.***	☐ 1=Live Birth ☐ 2=Spontaneous Abortion ☐ 3=Therapeutic Abortion ☐ 4=Fetal Death, >20 wks.
Gestational Age at Pregnancy Outcome	. weeks
Weight	lbs oz *or* g
Sex	☐ 1= Male ☐ 2= Female
Mother Breastfeeding?	☐ 1=Yes ☐ 2=No
Baby receiving WIC?	☐ 1=Yes ☐ 2=No
Health Check Exam or Well Child Care?	☐ 1=Yes ☐ 2=No
Referred to CSC?	☐ 1=Yes ☐ 2=No

Name(s) and signature(s) of person(s) completing form:

Print name: _____
Signature: _____ Date: ____/____/____

Print name: _____
Signature: _____ Date: ____/____/____

DHHS T1514 (Revised 4/23/07)
Women's Health (Review 4/08)

Page 3 of 4

DRAFT

Instructions for the Pregnancy Outcome Summary (POS)

Purpose:

To collect data on pregnancy outcomes for Maternal Health patients and/or Maternity Care Coordination Program clients. All Maternal Health patients and Maternity Care Coordination Program clients must have the POS completed within 30 days of discontinuation of services and submitted through the Health Services Information System (HSIS).

Preparation:

1. *Complete form, entering all required data.*
2. *Submit data into HSIS.*
3. *File original form in client's medical record.*

Disposition:

This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Historical Resources.

Additional forms may be ordered using the Requisition for Maternal Health Materials form (DHHS 3980), available at http://wch.dhhs.state.nc.us/whs.htm.

DHHS T1514 (Revised 4/23/07)
Women's Health (Review 4/08)

Page 4 of 4

DRAFT

F. Case Conference Summary, DMA 2011

MATERNITY CARE COORDINATION
CASE CONFERENCE SUMMARY

Instructions: The case conference must be documented on the MCCP Case Conference Summary form. See *Section 5.5, Case Conferencing, DMA MCCP Clinical Coverage policy*.

Participant's First Name, Middle Initial & Last Name	MID Number	Date of Birth	Prenatal Care Provider

Identify Family Strengths:_____

Needs/Concerns	Goals/Objectives	Contact Person/Agency	Resolved/ Ongoing

Services Family is Currently Receiving: Yes or No

MCW Services_____ WIC/Nutrition_____ Dietary Evaluation & Counseling_____ Food Stamps_____
Public Housing_____ Substance Abuse Services_____ Health & Behavior Intervention_____ Mental Health_____
Developmental Services_____ Transportation_____ Other Case Management_____ Other_____

List additional interventions recommend by the team for supporting the participant in reaching her goals, the responsible person and the anticipated date of action.

Interventions	Responsible Person	Anticipated Date of Action

Team Members in attendance at case conference:

Legal Signature	Title	Legal Signature	Title

Signature of Recorder_____ Title_____ Date_____

DMA 2011
09/07

DRAFT

G. Narrative Sheet, DMA 2008 (formerly DMA-3016)

MATERNITY CARE COORDINATION PROGRAM
NARRATIVE SHEET

Participant's Name	MID Number	Date of Birth	Prenatal Care Provider

Date	Type & Time of Contact (HV, 35 minutes=2 units)	Notes

DMA 2008
09/07